CITY OF LINCOLN

EMPLOYEE'S LTD STATEMENT

To be Completed by Employee

Name (Last, first, middle initial)	Social Security Number	Date of Birth	☐ Male ☐ Female
Home Address (Street number, city, state, zip code)		Telephone No. (Include Area Code)	
Mailing Address, if different from Home Address (Street number, city, state, zip code)		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	

Nature of illness and when symptoms first appeared:	Date first unable to work because of this disability:
	First date of medical treatment:
If due to injury, how and when did this accident occur?	How does illness/injury prevent you from returning to work?

Have you returned to work? ☐ Yes ☐ No If "Yes, on what date: _____ Part-time _____ Full-time

If you have not returned to work, on what date do you expect to return to work? _____ Part-time _____ Full-time

Have you engaged in any work, part-time or otherwise, during your period of disability? ☐ Yes ☐ No
If yes, attach explanation.

List primary physicians you consulted because of this disability. (Use other side if necessary)

Physician's Name	Address Phone No.	Dates Treated
1.	1.	1.
2.	2.	2.
3.	3.	3.

Have you applied for or are you receiving benefits from:	Applied Yes	Applied No	Receiving Yes	Receiving No	Date Applied For	Amount Received Weekly	Amount Received Monthly	Effective Date	Paid Thru Date
a. Social Security	☐	☐	☐	☐					
b. Workers' Compensation	☐	☐	☐	☐					
c. Salaries, Wages, Commissions, etc.	☐	☐	☐	☐					
d. Retirement or Pension	☐	☐	☐	☐					
e. Other	☐	☐	☐	☐					

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals or other institutions rendering care to furnish the City of Lincoln with full information regarding treatment rendered (including copies of their records)

Date _____ Employee's Signature _____

CITY OF LINCOLN

EMPLOYER'S LTD STATEMENT

To be Completed by Employer

Employee's Name (Last, first, middle initial)	Telephone No. (Include Area Code) ( )	Date of Birth
Address (Street number, city, state, zip code)		SSN
Occupation	Basic Duties	
Date of Hire	Date Last Worked	
Cause of Disability	Did Disability Occur Due to Occupational Causes? ☐ Yes ☐ No	
Basic Monthly Earnings $ _____	How is claimant paid? ☐ Hourly ☐ Salaried ☐ Other _____	
Has employee been laid off or has employment terminated? If so, when?		
Date employee returned to work or date expected to return		
To the best of your knowledge, is the claimant receiving, or entitled to receive benefits from any of the following sources? If "Yes," please explain. ☐ Salary continuance ☐ Workers' Compensation ☐ Retirement or pension ☐ Social Security ☐ Group Disability ☐ Other _____		
Policy Holder	Address	
Date	Signed By	Title

CITY OF LINCOLN

PHYSICIAN'S LTD REPORT

Notice to Employee: This form is to be completed and mailed to the office shown below.

EMPLOYEE BENEFITS AREA
CITY-COUNTY PERSONNEL DEPT.
555 S. 10TH ST.
LINCOLN, NE 68508

Patient's Name	Date of Birth
Patient's Address – Street, City, State, Zip Code	Phone Number (Area Code First)
Employer's Name	

MEDICAL CONDITION

(a) Diagnosis:

(b) Complications:

(c) Prognosis for a return to present occupation:

(d) Prognosis for a return to any employment:

(e) Is this a nervous or mental health condition? ____ Yes ____ No

HISTORY

(a) When did symptoms first appear or accident happen? Month _____ Day _____ Year _____

(b) Date of first visit: Month _____ Day _____ Year _____

(c) Date of last visit: Month _____ Day _____ Year _____

(d) Date you first advised patient to cease work: Month _____ Day _____ Year _____

TREATMENT

(a) What are the treatment plans?

(b) Surgery:

(c) Medications:

(d) Is further treatment required?

The Patient Has Been Continuously Disabled (Unable to Work) From _____
Through _____
If Still Disabled, When Should Patient Be Able to Return to Work? _____

Would job modification enable patient to work with impairment? ☐ Yes *(Describe.)* ☐ No

Name (Physician) Please Print	Specialty	Telephone ( )
Address – Street, City or Town, State or Province, Zip Code		
Signature		Date

CITY OF LINCOLN
LTD AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name: _____ Phone Number _____

Address _____

City: _____

State/Zip: _____

I am either the patient named above or the patient's legally authorized representative. By signing this form, I authorize the following medical provider(s):

_____

_____

_____

To disclose my protected health information to the individuals or organizations listed below:

City of Lincoln

The specific type of information to be disclosed shall consist of true, correct, and complete copies of all medical records of any kind, including, but not limited to, medical reports, consultation reports, doctors' notes, nurses' notes, correspondence, and documentary material of any kind, including but not limited to drug or alcohol records and health information related to psychological or psychiatric conditions, including psychotherapy notes, relating in any way to treatment of the above described patient rendered by the above described provider.

The purpose and need of such disclosure is to receive long term disability (LTD) benefits.

Expiration: Without express revocation, this consent shall expire one year from the date of this authorization.
Revocation: I understand that I may revoke this consent by providing written notice to the above mentioned provider at any time except to the extent that the provider has taken action in reliance on this authorization. I may revoke the consent by providing a written notice to the Provider listed above.
Prohibition of Conditioning of Treatment: I understand that the provider's treatment to me is not contingent upon my decision to provide or withhold consent or release information.
Further Uses and Disclosures: I understand that there is a potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected by federal privacy laws.

I understand that a photocopy or a faxed copy of this authorization will be considered as valid as the original.

_____ _____
Printed Name (Employee/Patient) Date of Birth

_____ _____
Signature (Employee/Patient) Social Security Number

_____, 20__
Date